County of San Bernardino
Department of Behavioral Health

CHANGE OF PROVIDER REQUEST FORM—SIDE 1

As a consumer of behavioral health services, you have the right to request a change if you are not satisfied with your current service provider. Requesting a change of provider does not put you at risk of being denied behavioral health services or having the type of services you received changed.

If you would like to request a change of provider, please fill out this form as best you can in your own words. You can get help with filling out this form from the clinics supervisor at the location where you are receiving services, from the ACCESS Unit at (888) 743-1478, or from the Patients' Rights Office at (800) 440-2391.

Once you have filled out this form, please turn it into the receptionist at the clinic where you are currently receiving services.

Client's Name_____ **Date of Birth** _____

Telephone Number _____ **Social Security Number** _____

1. **What is the name of the provider you would like to have changed?** _____

_____

2. **Why are you asking for a change in provider?** _____

_____

_____

_____

_____

_____

3. **What type of change do you want?** _____

_____

4. **Did you talk to your current provider about your request for a change?**

   Yes ☐ **No** ☐

5. **What did your current provider say?** _____

_____

_____

_____

County of San Bernardino
Department of Behavioral Health

San Bernardino County Department of Behavioral Health

CHANGE OF PROVIDER REQUEST FORM—SIDE 2

THIS SIDE IS FOR STAFF USE ONLY

Name of Outpatient Clinic: _____

Clinic Response to Client Request: _____

_____

_____

Approvals:

Signature_____ _____
Clinic Supervisor **Date**

Signature_____ _____
Clinic Medical Director **Date**

NOTE: This form should be sent to the QUALITY MANAGEMENT DIVISION (850 E. Foothill Blvd. Rialto, CA 92376/or interoffice to mail code: 0920) by the 5th day of the month following that in which the change was requested.